

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 10/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/28/2016
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NAME OF PROVIDER OR SUPPLIER ARMA OPERATOR, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 E MELVIN STREET PO BOX 789 ARMA, KS 66712
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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations # 106530, 106524 and 107026.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility reported a census of 40 residents with 5 residents reviewed for care planning. Based on observation, interview, and record review, the facility failed to review and revise the plans of care for 2 of the 5 residents reviewed (#5 and 2) related to toileting. Findings included: - Resident #5 ' s signed physician orders, dated	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	<p>Continued From page 1</p> <p>8/16/16 included a diagnosis of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain).</p> <p>An admission MDS assessment, dated 7/20/16 identified the resident scored 3/15 on the Brief Interview for Mental Status assessment, indicating severely impaired cognition and needed extensive assist of 1 staff for transfers and locomotion, and needed limited assistance of 1 staff for walking and toileting. The assessment identified the resident lacked a toileting program and was always continent of bladder.</p> <p>The 7/22/16 Care Area Assessment for urinary incontinence included: The resident calls for assistance for toileting and is continent of bladder at that time</p> <p>The quarterly Minimum Data Set assessment, dated 9/23/16, identified the resident scored 3/15 on the Brief Interview for Mental Status assessment, indicating severely impaired cognition and indicated the resident as frequently incontinent of urine and on a toileting program.</p> <p>A voiding evaluation, dated 10/4/16 identified the resident incontinent of urine and needed habit training and scheduled voiding. Documentation indicated the staff prompt and assist the resident to the toilet every 2 hours and PRN (as needed). The evaluation lacked a voiding diary, to determine the resident's individual toileting needs.</p> <p>The resident ' s care plan, dated 7/28/16 included:</p> <p>The resident is continent of bladder, at that time, however, resident does experience urgency and</p>	F 280			

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F 280	<p>Continued From page 2</p> <p>needs his/her call light answered immediately.</p> <p>On 10/12/16 staff changed the care plan to reflect the resident required 1 staff participation to use the toilet. Staff to prompt and assist to the toilet every 1-2 hours during AM/PM and every 2-3 hours at bedtime. The plan of care failed to address the resident's individualized toileting needs.</p> <p>On 10/18/16 at 10:45 AM the resident sat in the recliner in his/her room, covered with a blanket and appeared to sleep. Intermittent observations from 10:45 AM until 1:00 PM, at 11:00, 11:15, 11:30, 11:45, 12:00, 12:15, 12:30, and 12:45 PM identified no significant changes in the resident's position or care provided by any staff member, per interview with the resident's visiting family. At 1:00 PM, direct care staff K assisted the resident to the toilet then licensed nursing staff D stepped in to assist with completion of cares. Staff K reported the brief they removed from the resident was wet with urine and reported that sometimes the resident was wet and sometimes was continent of urine. Staff provided perineal care to the resident and then placed a clean brief on the resident.</p> <p>10/20/16 at 3:10 PM, direct care staff I and licensed nurse E, assisted the resident with toileting, ambulating to the bathroom. The resident was noted to have a wet brief, with staff providing perineal care to the buttocks and front perineal areas before placing a dry brief on the resident.</p> <p>Direct care staff K reported, on 10/18/16 at 2:30 PM, the resident was often continent of bladder and that he/she needed toileting every 2 hours or sooner when requested.</p>	F 280			

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F 280	<p>Continued From page 3</p> <p>On 10/19/16 at 4:46 PM, direct care staff M, reported the resident was total care and incontinent of bladder with a toileting plan of every 2 hours. Staff reported they had never completed a 3 day voiding pattern on any resident in the facility.</p> <p>On 10/19/16 at 9:30 AM, licensed nursing staff F, reported the resident was incontinent of urine and needed toileting assistance of staff.</p> <p>On 10/20/16 at 2:15 PM administrative nursing staff C reported the plan of care needed to be individualized to each resident and agreed the resident had changed in several areas, including toileting.</p> <p>The facility policy dated 8/15, for Urinary Incontinence, included using a standardized assessment tool to determine the cause of the incontinence and determining the resident ' s type of voiding program needed.</p> <p>The facility policy, dated 9/12, included the care planning team would review and update the plan of care when a significant change in the resident ' s condition occurred.</p> <p>The facility failed to review and revise the plan of care to ensure the staff provided a consistent toileting plan for this resident with a recent onset of incontinence, based on the resident's individual needs.</p> <p>- RESIDENT # 2 ' s admission Minimum Data Set assessment, dated 5/20/16, included the resident unable to complete the Brief Interview for Mental Status assessment and staff assessed the resident with intact memory, and needed total</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>dependence for bed mobility, transfers, toileting and personal hygiene with functional limitation in ROM to bilateral sides to upper and lower extremities. The assessment identified the resident always incontinent of bladder.</p> <p>The quarterly Minimum Data Set assessment, dated 7/27/16, indicated the resident scored 6/15 on the Brief Interview for Mental Status assessment, without changes to his/her ADL ' s or incontinence status.</p> <p>The 5/20/16 Care Area Assessment for cognition included: Resident appears to have some cognitive deficits. The extent is unknown d/t the resident ' s inability to respond consistently.</p> <p>The 5/20/16 Care Area Assessment for UI included Resident will remain free from skin breakdown due to incontinence and brief use. Nursing will check and change every 2-3 hours and as required for incontinence and wash, rinse and dry perineum with every incontinent episode. Change clothing PRN after incontinence episodes.</p> <p>A 10/15/16 urinary evaluation included the resident was incontinent of urine following a 3 day voiding diary, identified the resident would require a habit/scheduled voiding program, related to mixed incontinence. The evaluation lacked a voiding diary, to determine the resident's individual toileting needs.</p> <p>A care plan, dated 10/10/16, included:</p> <p>7/15/16 BRIEF USE: use disposable briefs for dignity. Wash, rinse and dry perineum with every incontinent episode. Change clothing PRN (as needed) after incontinence episodes.</p>	F 280		

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F 280	<p>Continued From page 5</p> <p>9/20/16 TOILETING ROUTINE: Toilet every 1 hour until the residents brief is not wet for 12 toiletings then increase to every 2 hours and notify staff to update the care plan. The resident is to be toileted 1 time each shift on the commode. The plan of care failed to address the resident's individualized toileting needs.</p> <p>On 10/18/16 at 8:38 AM, direct care staff K and L checked the resident for wetness after laying the resident in the bed, and found the resident to be dry. No offer of toileting was made. Staff K reported the resident is incontinent of urine at all times. At 11:33 AM direct care staff K and L checked and changed the resident and removed a urine wet brief, provided perineal care appropriately and then transferred the resident into a broda chair for lunch. Again, no offer of toileting was made or attempted. At 3:00 PM, the resident was restless and calling out to staff to get him/her up. Staff P responded to the resident that it was too early to get out of bed before supper. During this interaction, the staff failed to offer toileting, check and change or any type of cares to alleviate the resident ' s restlessness. At 4:30 PM, direct care staff P and Q changed the resident ' s wet incontinent brief and provided perineal care before transferring the resident into the broda chair.</p> <p>Direct care staff K reported on 10/18/16 at 2:53 PM, the resident was incontinent of bladder and staff checked and changed the resident routinely , and were suppose to toilet the resident 1 time per shift. The staff reported the resident is planned for check and change every hour, but confirmed that did not always happen. Staff reported the resident is not resistant to cares at all.</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>On 10/19/16 at 4:55 PM, direct care staff M reported the resident required total care for ADL ' s (activities of daily living), was incontinent of bladder and rarely ever toileted. The staff reported the resident seemed to be getting some sensation of voiding back, as the resident will frequently state he/she is wet, but when checked he/she is not. The resident needed much encouragement for toileting on the commode.</p> <p>On 10/20/16 at 2:15 PM administrative nursing staff C reported the plan of care needed to be individualized to each resident and agreed the resident ' s condition had improved and the current plan of care was no longer being used and the care planned needed updating</p> <p>The facility policy dated 8/15, for Urinary Incontinence, included using a standardized assessment tool to determine the cause of the incontinence and determining the resident ' s type of voiding program needed.</p> <p>The facility policy, dated 9/12, included the care planning team would review and update the plan of care when a significant change in the resident ' s condition occurred.</p> <p>The facility failed to review and revise the plan of care to ensure an individualized toileting plan to consistently toilet this resident to restore as much normal bladder function as possible.</p>	F 280			
F 314 SS=E	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that</p>	F 314			

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F 314	<p>Continued From page 7</p> <p>they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 40 residents with 5 residents selected for sample review of pressure ulcers. Based on observation, interview, and record review the facility failed to assess and consistently provide pressure relieving interventions for 4 of the 5 residents reviewed, resident #'s 2, 3, 4 and 5, as planned.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #5's admission Minimum Data Set assessment, dated 7/20/16 identified the resident scored 3/15 on the Brief Interview for Mental Status assessment, indicating severely impaired cognition and needed extensive assistance of 1 staff for bed mobility and transfers. <p>A pressure ulcer assessment indicated the resident lacked a pressure ulcer upon admission and a clinical assessment identified the resident as not at risk for the development of a pressure ulcer. The assessment identified the implementation of a pressure reducing device for the bed and chair, with a turning/repositioning program, and without nutrition/hydration interventions.</p> <p>The 7/22/16 Care Area Assessment for cognition included: The resident with impaired cognitive function/dementia or impaired thought processes related to dementia, impaired decision making, long term memory loss, and short term memory loss.</p>	F 314			

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F 314	<p>Continued From page 8</p> <p>The 7/22/16 Care Area Assessment for pressure ulcers included the resident was at risk for pressure ulcers related to weight loss and decreased mobility, which required 1 staff for repositioning and turning in bed. The care area included that staff should complete daily skin inspections with cares with observation for redness, open areas, scratches, cuts and bruises, with changes in skin condition reported to the charge nurse. The charge nurse was responsible for completion of the weekly skin assessment.</p> <p>The quarterly Minimum Data Set assessment, dated 9/23/16, identified the resident scored 3/15 on the Brief Interview for Mental Status assessment, indicated severely impaired cognition, and required extensive assist of 2 staff for bed mobility and transfers. The pressure ulcer assessment indicated the resident at risk for the development of pressure ulcers, however, currently without pressure ulcers.</p> <p>Review of the Braden skin risk assessments, indicated the resident admitted with a low risk of development of a pressure ulcer of 19 on 7/15/16.</p> <p>The care plan implemented on 7/28/16 included the following instructions to staff:</p> <ol style="list-style-type: none"> 1. The resident required skin inspections daily with cares. Observe the resident for redness, open areas, scratches, cuts, and bruises and report changes to the Nurse. The charge nurse must complete a weekly skin assessment and report changes to the primary care physician. 2. The staff added to the care plan on 10/19/16: 	F 314			

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F 314	<p>Continued From page 9</p> <p>Pressure relieving/reducing cushion in the wheelchair and bed.</p> <p>3. Administer treatments, as ordered and monitor for effectiveness.</p> <p>4. Apply moisturizer to the resident ' s skin. Do not massage over bony prominences and use mild cleansers for perineal care/washing.</p> <p>5. The resident needed monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested.</p> <p>6. Wash buttocks gently- do not rub, pat to dry and then apply barrier cream with each incontinent episode.</p> <p>Review of the physician ' s telephone orders, dated 10/18/16, identified the physician ordered barrier cream, twice daily.</p> <p>A 10/18/16 nursing note, timed at 10:48 AM, included a focus review of a wound to the resident ' s bilateral buttocks. The staff documented the resident had areas of shearing or excoriation to the left buttock, measuring 2.4 cm (centimeter) by 2 cm, and to the right buttock measuring 1 by 1 cm. Staff documented the areas as superficial, with barrier cream and staff placed a pressure relieving cushion in the chair. Review of the documentation in nursing notes lacked documentation of any previous notes of the wound areas.</p> <p>On 10/19/16 at 1:20 PM, nursing documentation noted the left buttock with an open area, measuring 2.3 cm by 1.8 cm. Staff documented the right buttock exhibited an open area of 1 cm</p>	F 314		

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F 314	<p>Continued From page 10</p> <p>by 1 cm, with barrier cream applied and the staff placed the resident in a wheelchair, with a pressure cushion in the chair, in place.</p> <p>On 10/18/16 at 10:45 AM, the resident observed to sit in the recliner in his/her room, with the resident covered with a blanket. The resident appeared to be asleep, at that time. Frequent observations at 11, 11:30, 11:45 AM, and 12, 12:15, 12:30, and 12:45 PM identified the resident remained in the recliner, without any significant position change. The resident's children remained with the resident throughout most of that time and reported the staff did not come and complete any cares with the resident during that time. The children assisted the resident to eat his/her lunch.</p> <p>At 1:00 PM on 10/18/16, the resident's children reported the resident needed assistance with toileting. Direct care staff K, assisted the resident into the toilet and sat the resident onto the toilet. The resident complained of his/her bottom hurting and wanted off the toilet. Direct care staff K and D returned to the room to assist the resident off the toilet and provide perineal care. Observation at that time identified the 2 areas on the resident's backside, one area immediately at the base of the coccyx appeared very dark in color and possibly deep, and the second area appeared as superficial shearing with the top layer of skin gone, oval in shape, without drainage, and pink skin observed. Licensed nursing staff D applied barrier cream to both areas, during the application of the ointment, and the resident stated, "Ow." The aide stated to the resident the area might be a little tender while the nurse applied the ointment.</p> <p>On 10/20/16 at 9:32 AM, the resident sat in</p>	F 314			

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F 314	<p>Continued From page 11</p> <p>his/her recliner in his/her room, leaning over the arm of the chair on the right side, with the resident ' s right arm dangling. Licensed nurse E gowned and gloved, and then entered the resident ' s room, to attempt to reposition the resident. The resident declined to allow staff to position a pillow to assist the resident in maintaining a more upright position, however, he/she did allow the nurse to lean the back of the recliner down. Staff E noted, at that time, the recliner lacked a pressure relieving cushion and the cushion remained in the wheelchair. Staff confirmed the cushion should be under the resident.</p> <p>On 10/20/16 at 3:10 PM, direct care staff I and licensed nurse E, assisted the resident with toileting. The staff removed a wet brief, then provided perineal care to the buttocks and front perineal areas. The resident lacked a dressing to the two areas, and staff failed to apply barrier cream as planned in the plan of care to the area when cleaned. Interview, at that time, with licensed staff E confirmed the area at the base of the coccyx appeared to have some depth and estimated the area might be 0.1 cm in depth.</p> <p>Interview on 10/18/16 at 12:00 PM, with the resident ' s family members reported the resident admitted to the facility without any skin issues. The family then mentioned, when visiting on the previous day, the resident had a pressure ulcer to the coccyx area. The family asked staff about it, at that time and 4 staff members denied knowledge of the open area, prior to that time.</p> <p>On 10/18/16 at 2:30 PM, direct care staff K reported the resident needed help with all ADL ' s (activities of daily living) and the staff needed to toilet the resident approximately every 2 hours or</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER ARMA OPERATOR, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 605 E MELVIN STREET PO BOX 789 ARMA, KS 66712		
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F 314	<p>Continued From page 12</p> <p>sooner, if he/she asked for assistance. Staff K reported the 2 areas on the resident's bottom started last week, and stated when the staff assisted the resident with his/her shower, the washcloth had blood on it when he/she provided pericare for the resident. Staff K reported a shower sheet with the information about the area on the resident ' s bottom was given to the nurse, last week after the shower. The staff further noted the resident needed repositioning side to side in bed, keep the resident as dry as possible and probably should not be in the recliner so much during the day.</p> <p>On 10/19/16 at 4:46 PM, direct care staff M, reported the resident was total care and observed something on his/her bottom last week, during bathing. The staff reported the staff had been applying barrier cream and tried to keep the resident positioned off his/her backside, with turning and repositioning every 1 ½ to 2 hours. The resident also was to have a pressure relieving cushion in his/her wheelchair, in the recliner and on the bed.</p> <p>On 10/19/16 at 9:30 AM, licensed nursing staff F, reported the resident was to have pressure relieving cushions to the wheelchair and the recliner, and reported staff documented the area as shearing, but staff F had not seen or treated the wound, as yet.</p> <p>The facility policy, titled " Repositioning, " dated 10/10, included that assessment of a resident ' s skin integrity should guide the development and implementation of repositioning plans. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Positioning the resident on an existing pressure ulcer should be avoided since it</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>puts additional pressure on tissue that is already compromised and may impede healing.</p> <p>The facility failed to ensure the resident received care and services, to promote the healing of the resident ' s pressure ulcers, including failure to provide timely repositioning, and toileting, and provision of consistent pressure relief on all surfaces, as planned, and timely assessment of the wound, after it developed, as the staff failed to document the wounds size and a description for all staff ' s knowledge.</p> <p>- Resident #3 ' s significant change Minimum Data Set assessment, dated 5/25/16 included a Brief Interview for Mental Status assessment score of 10/15, indicating moderately impaired cognition. The assessment further identified the resident was totally dependent on staff for ADL ' s (activities of daily living), at risk for the development of pressure ulcers, without a pressure ulcer at that time and with pressure relieving devices for the chair and bed, and with a turning and repositioning program in place with nutrition management for skin problems.</p> <p>The quarterly Minimum Data Set assessment, dated 8/11/16, lacked changes to the Brief Interview for Mental Status assessment, pressure ulcer risk, skin condition, or mobility needs.</p> <p>The Care Area Assessment, dated 6/2/16, for pressure ulcers included: the resident was at risk for pressure ulcers due to decreased mobility, occasional bowel incontinence, resistant to turning, with extensive edema, protruding abdomen and decreased appetite.</p> <p>Review of the resident ' s Braden Skin Risk</p>	F 314			

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F 314	<p>Continued From page 14 assessments included:</p> <p>4/27/16 16 (low risk)</p> <p>5/25/16 12 (high risk)</p> <p>10/1/16 13 (moderate risk)</p> <p>The residents care plan, dated 3/9/16, included the following interventions:</p> <p>3/21/16 Monitor/remind and assist the resident to reposition at least every 2 hours, more often as needed or requested. Use pillows to off load pressure to each side since the resident doesn't lie down in a bed. Float his/her heels in the chair and remind him/her to relieve pressure every 2-3 hrs. (The resident is moderately impaired cognitively.)</p> <p>3/21/16 Administer medications as ordered. Monitor/document for side effects and effectiveness.</p> <p>3/21/16 Educate the resident and his/her family as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning.</p> <p>3/21/16 Follow facility policies/protocols for the prevention/treatment of skin breakdown and frequently remind the resident to try and adhere to them.</p> <p>3/21/16 If the resident refuses treatment, confer with him/her, IDT (interdisciplinary team) and the family to determine why and try alternative methods to gain compliance. Document alternative methods.</p>	F 314			

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F 314	Continued From page 15 3/21/16 Provide pressure relieving/reducing wheelchair cushion, pillows to off load pressure in recliner. 7/21/16 Provide a pressure relieving cushion in the resident ' s recliner and a pressure reducing mattress on his/her bed. 7/21/16 Charge nurse to complete a skin inspection weekly and report changes to the PCP (primary care physician). Observe for redness, open areas, scratches, cuts, bruises and report changes in the resident ' s skin to the nurse. 7/21/16 Lately the resident had been feeling fatigued, tired and refused cares. Please cluster his/her care and allow him/her more rest time in between tasks. Review of the facility Wound Logs, provided to include all residents receiving wound care, reviewed for 3 months, August, September and October, 2016, lacked documentation of the monitoring of the resident's wounds including: Review of the weekly skin evaluations, in PCC (point click care-computer charting) included the following: 8/27/16 Redness to coccyx - treatment in place. 9/3/16 Skin intact. 9/10/16, 9/19/16 and 9/26/16 -- Coccyx red - cream applied as ordered - tolerated well. 10/3/16 Continue with redness and open area to the buttocks, treatment in place.	F 314			

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F 314	<p>Continued From page 16</p> <p>10/12/16 Redness continues to coccyx - treatment in place.</p> <p>On 10/18/16 at 8:24 AM, direct care staff K and another unidentified staff transferred the resident from the wheelchair into the recliner. Both chairs identified with a pressure relieving cushion present and a low air loss mattress noted on the bed. Frequent observations from 8:24 until 11:00 AM, at 8:30, 8:45, 9:00, 9:15, 9:30, 9:45, 10:00, 10:15, 10:30, 10:45 and 11:00 AM, identified the resident remained in the recliner until 11:00 AM, for 2 ½ hours, when a hospice aide and another unidentified staff transferred the resident onto the bed, for a bed bath. At 11:13 AM, licensed nursing staff D and direct care staff I assisted the hospice aide with completion of the bathing and rolled the resident onto his/her side. Observation identified the entire sacrum (coccyx) area as a darkened reddish purple area, with an approximate area of 1 ½ inches in length area on the lower right buttock, which contained 2 open areas, 0.5 cm (centimeters) each, at each end of the elongated area. Licensed staff D applied barrier cream to all areas of the sacrum, without any other treatment, other than cleaning and confirmed the presence of the open areas, within an excoriated area. Staff described the excoriation as being yeast. Following completion of the resident ' s bath, at 11:20 AM, staff transferred the resident to the recliner, seated onto a pressure relieving cushion and placed a pillow under the resident ' s lower legs and heels, failing to off-load the pressure from the resident ' s heels, when staff placed the resident ' s heels directly onto the pillow. Intermittent observation, at 11:45 AM, 12:00 PM, 12:15 PM, 12:30 PM, 12:45 PM, 1:00 PM, and at 1:30 PM, revealed the resident had completed lunch and remained seated in his/her the recliner, with his/her eyes</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>closed. (a period of 2 hours and 20 minutes). No additional pillows or repositioning devices noted in the chair with the resident's heels remaining directly on the pillow on the footrest of the recliner.</p> <p>On 10/18/16 at 2:49 PM, direct care staff K, reported the resident is total care except for eating which is limited assistance. The staff reported the resident ' s area on his/her bottom had been present for 2-3 months, getting better then worse. The staff reported the only treatments he/she ever knew of were the use of barrier cream and nystatin, no dressings were used. The staff reported the resident needed repositioning every 2 hours and to keep the resident ' s heels offloaded.</p> <p>Direct care staff O reported, on 10/18/16 at 2:55 PM the staff had not provided any cares to the resident since coming on at 2:00 PM but the staff would be getting him/her up shortly for supper. At 4:07 PM direct care staff N and O placed gripper socks on the resident ' s bare feet, after removing the pillow the heels rested directly on. The resident ' s heels appeared reddened but blanchable. Staff used a mechanical lift, to lift the resident from the recliner onto the bed, to check the resident ' s brief for incontinence. The staff transferred the resident into the wheelchair after completion of cares.</p> <p>On 10/19/16 at 9:35 AM licensed nursing staff F reported the resident needed repositioning at least every 2 hours related to areas on the resident ' s bottom. Staff are expected to reposition the resident frequently and the resident had pressure relieving cushions in both the wheelchair and the recliner and a low air loss mattress on the bed.</p>	F 314			

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F 314	<p>Continued From page 18</p> <p>On 10/19/16 at 4:15 PM, direct care staff S reported the resident needed to be kept repositioned, using the wedge to reposition in the bed and pillows in the recliner to position and relieve pressure from the buttocks. Staff reported the resident had, had open areas and other skin problems for quite some time, and indicated that about a month ago the area was healed, and now is reopened. The staff further reported the resident needed his/her heels floated and reported placing the resident ' s heels onto the pillow is not offloading, that the pillow should be further up under the calf of the leg.</p> <p>On 10/19/16 at 4:30 PM, administrative nursing staff B reported the resident frequently refused to reposition and could become very verbal about repositioning with the staff. Staff B reported they were not aware of any re-education with the resident, who had impaired memory, about repositioning and the benefits and risks of not doing so.</p> <p>On 10/20/16 at 3:45 PM, administrative nursing staff B stated he/she was not sure if staff measured the areas, but was aware the licensed nurses were completing treatments to the area on a twice a day basis. The staff reported the licensed staff had not reported any open areas on the sacrum prior to 10/18/16.</p> <p>The facility policy, titled " Repositioning, " dated 10/10, included that assessment of a resident ' s skin integrity should guide the development and implementation of repositioning plans. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Positioning the resident on an existing pressure ulcer should be avoided since it</p>	F 314			

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F 314	<p>Continued From page 19</p> <p>puts additional pressure on tissue that is already compromised and may impede healing.</p> <p>The facility failed to provide repositioning timely for this resident, or provide encouragement to the resident to do so. Additionally, the facility failed to consistently float the resident ' s heels and failed to accurately assess the resident ' s wounds.</p> <p>- Resident # 2 ' s admission Minimum Data Set assessment, dated 5/20/16, included the resident unable to complete the Brief Interview for Mental Status assessment and staff assessed the resident with intact memory. The staff also assessed the resident needed total dependence for bed mobility, eating, toileting and with functional limitation in ROM (range of motion) to bilateral sides of the upper and lower extremities. The resident had a pressure relieving device for the bed, on a turning and repositioning program due to being at risk for the development of a pressure ulcers, however assessed the resident without a pressure ulcer, at that time.</p> <p>The quarterly Minimum Data Set assessment, dated indicated the resident scored 6/15 on the Brief Interview for Mental Status assessment, with the ADL ' s (activities of daily living) remaining the same, as did the pressure ulcer information, from the prior assessment.</p> <p>The 5/20/16 Care Area Assessment for cognition included: Resident appears to have some cognitive deficits. The extent is unknown d/t the resident ' s inability to respond consistently.</p> <p>The 5/23/16 Care Area Assessment for pressure ulcers included: Due to being dependent for all cares and incontinent of bowel and bladder, the resident is at risk for pressure ulcers. The staff</p>	F 314			

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F 314	<p>Continued From page 20 will provide all cares, including turning and repositioning.</p> <p>Review of the Braden Skin Risk assessments, included:</p> <p>5/11/16 11 (high risk)</p> <p>6/1/16 13 (moderate risk)</p> <p>7/20/16 13 (moderate risk)</p> <p>Review of the 10/10/16 care plan included:</p> <p>5/24/16 Float the resident ' s heels or provide protective heel boots while in bed. Place elbows on pillows and place a pillow between bony prominences to prevent breakdown.</p> <p>5/24/16 Pressure relieving/reducing air mattress to protect skin while in bed.</p> <p>5/24/16 Identify/document potential causative factors and eliminate/resolve where possible.</p> <p>5/24/16 Turn and reposition the resident every 2-3 hrs. When in bed, the resident can hold the side rails if staff assist my arm to the rail.</p> <p>9/20/16 BED MOBILITY: Extensive assist with 2 staff for repositioning and turning in bed to reduce pain and for safety to prevent falls.</p> <p>6/13/16 TRANSFER: Required 2 staff participation with a mechanical lift for transfers.</p> <p>6/13/16 SKIN INSPECTION: Skin inspection daily, during cares. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. Charge nurse to perform</p>	F 314		

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F 314	<p>Continued From page 21 weekly skin assessments.</p> <p>Review of Weekly skin assessments, from 7/12/16 to 10/18/16 revealed no concerns regarding pressure ulcers.</p> <p>On 10/18/16 at 8:38 AM, direct care staff L and K transferred the resident from a broda chair, with a thick PR cushion in seat, to the bed, also with a pressure relieving mattress. The staff provided check and change for the resident after the transfer into the bed. Staff K reported the staff turn and reposition the resident every 2 hours, and does move about in the bed independently as well. Staff reported the resident ' s skin in good condition, and without any pressure ulcers. Staff identified the resident had pressure relieving devices to the bed and wheelchair as well. Observation identified the resident had a 5-6 cm (centimeters) circular area to the left buttock cheek, that was blanchable. Staff K noted this is an on-going red spot for the resident and sometimes needed barrier cream. Staff left the resident resting on his/her back, without any attempts to position onto him/her side or make any attempt to offload the resident ' s heels.</p> <p>Observation, on 10/18/16 at 1:00 PM, identified the resident in bed, positioned on his/her back without any heel offloading. Observations every 15 minutes until 3:00 PM identified the resident made slight movements, however, no significant side to side turning. At 3:00 PM, direct care staff L responded to the residents calling out. The resident rested on his/her back, without any heel offloading. Staff L reported to the resident, who called out asking to get up, that it was too early to get up for supper. Staff failed to offer any repositioning or care for the resident, at that time. The resident remained on his/her back side.</p>	F 314			

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F 314	<p>Continued From page 22</p> <p>Continued intermittent observations identified the resident remained in the same position, without significant change at 1:15, 1:30, 1:45, 2:00, 2:10, 2:25, 2:40, 2:55, 3:15, 3:30, 3:45, 4:00 and 4:15 PM. At 4:30 PM, direct care staff P and Q provided check and changing of the resident ' s brief, and then assisted the resident into the broda chair. The staff failed to provide a position change and offloading of the resident ' s heels for 3 and ½ hours.</p> <p>On 10/19/16 at 4:55 PM, direct care staff M reported the resident required total care for ADL ' s (activities of living), except for eating, used the grab bar to assist in turning in bed and does move in bed independently and would not stay off his/her back. Staff reported the resident was sometimes reddened in the groin folds and buttocks.</p> <p>On 10/18/16 at 9:30 AM, licensed nursing staff D reported the resident had no pressure ulcer concerns, at that time.</p> <p>On 10/19/16 at 9:38 AM licensed nursing staff F reported the resident needed turning and repositioning every 2 hours and lacked any pressure ulcer concerns, at that time.</p> <p>The facility policy, titled " Repositioning, " dated 10/10, included that assessment of a resident ' s skin integrity should guide the development and implementation of repositioning plans. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing.</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>The facility failed to ensure the resident received turning, repositioning, and offloading of his/her heels, in a timely manner to ensure the resident did not develop pressure ulcers.</p> <p>- Resident #4 ' s annual Minimum Data Set, dated 9/25/16, included the resident scored 15/15 on the Brief Interview for Mental Status assessment, and needed limited to extensive assistance of staff for all ADL ' s (activities of daily living), except eating. The assessment identified the resident had MASD (moisture associated skin disorder), an open lesion of the foot (toe), and a pressure relieving device for the chair.</p> <p>The 10/7/16 Care Area Assessment for ADL ' s included: The resident needed assistance with ADL's due to blindness and limitations in mobility at times. The resident sleeps in the recliner per his/her choice as he/she had done for many years for comfort and ease of mobility and is continent of bladder.</p> <p>The 10/7/16 Care Area Assessment for pressure ulcers included: the resident is at risk for pressure ulcers related to limits in mobility. The risk for pressure ulcers will be minimized by applying cream for gaulding, and a cushion to the recliner or wheel chair, wherever he/she is seated. CNA ' s (certified nurse aides) are to inspect skin with showers and routine care and report skin issues such as bruises, pressure ulcers, redness, immediately to the charge nurse. Nurses are to complete weekly skin evaluations and report new or worsening areas to the PCP (primary care physician). The resident makes major changes in body position while sleeping/seated in the recliner.</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>The resident ' s Braden Skin Risk Assessment identified the following:</p> <p>9/20/16 - 16 low risk</p> <p>12/20/15 -- 17 low risk</p> <p>6/8/16 -- 21 (the lower the number the less risk for breakdown), however, the assessment lacked a score.</p> <p>9/8/16 - 21 (the lower the number the less risk for breakdown), however, the assessment lacked a score.</p> <p>The resident ' s care plan, dated 10/19/16, included:</p> <p>Apply cream for gauding, as ordered</p> <p>Apply cushion to recliner or wheel chair, wherever he/she was seated.</p> <p>CNA ' s to inspect skin with showers and routine care. Report skin issues such as bruises, pressure ulcers, and redness, immediately to the charge nurse.</p> <p>9-19-16 Ensure resident takes Prostat; remind resident it helps with wound healing.</p> <p>Nurses to complete weekly skin evaluations and report new or worsening areas to the PCP (primary care physician).</p> <p>Resident capable of making major changes in body position.</p> <p>Sleeps in recliner, per choice.</p>	F 314		

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F 314	<p>Continued From page 25</p> <p>The physician ' s orders, dated 5/10/16, included:</p> <p>Prostat, one time a day, related to End Stage Renal Disease, 30 ml (milliliters) daily, ordered 7/12/16.</p> <p>Calmoseptine Ointment, 0.44-20.6%, Apply to buttocks /coccyx topically one time a day related diabetes mellitus with neuropathy, 6/1/16.</p> <p>Review of weekly skin condition reports, documented in the computer, related to the resident ' s coccyx area included:</p> <p>9/26/16 Coccyx: Red, excoriated - cream applied - tolerated well.</p> <p>10/3/16 Buttocks: Redness noted, open area on buttocks measuring 10 cm (centimeter) in length and 5 cm in width.</p> <p>10/10/16 Buttocks: redness and continued current treatment and wheelchair/chair cushion.</p> <p>10/17/16 Buttocks 10 cm x 5 cm, blanchable redness and a slightly open area on bilateral buttocks.</p> <p>On 10/18/16 at 8:15 AM, the resident sat in the recliner in his/her room, eating breakfast. The resident appropriately responded to questions asked and reported they called for any assistance needed. Noted the resident ' s wheelchair had a pressure relieving cushion in the seat of the chair, in the room. On 10/18/16 at 8:30 AM, licensed nursing staff D identified the resident had concerns for skin breakdown and received a treatment to his/her bottom daily. At 3:12 PM, licensed nurse D completed a treatment to the resident ' s buttocks. The area exhibited a thick</p>	F 314			

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F 314	<p>Continued From page 26</p> <p>skin of scar tissue, and free of open areas at that time. Staff D cleaned the area, and then applied a thick coat of zinc based barrier cream to the entire area. The resident ' s recliner lacked a pressure relieving cushion in the seat, at that time. The resident returned to a seated position in the recliner, after the nurse completed the treatment, and remained without a pressure relieving cushion.</p> <p>On 10/18/16 at 2:44 PM, direct care staff K, reported the resident required limited assist to independent with ADL care. The resident stayed in his/her room most of the time, seated in the recliner, where he/she also sleeps. The staff reported the resident calls for any assistance needed, and does have issues with his/her bottom, sometimes with open areas, and other times not open.</p> <p>On 10/19/16 at 4:52 PM, direct care staff M reported the resident mostly stayed in his/her room, although at times asked staff to take him/her for short walks in the hallway. The resident was blind, but fairly independent, and needed a lot of cueing and guidance for ADL ' s. Staff reported the resident was always continent of bowel and bladder and slept in his/her recliner.</p> <p>On 10/19/16 at 9:25 AM, licensed nursing staff F, reported the resident ' s bottom does become red at times, as the resident sat all the time, but moved him/herself in the chair, as desired. Staff confirmed the recliner lacked a cushion, but was very likely in the wheelchair with the resident, at dialysis.</p> <p>The facility policy, titled " Repositioning, " dated 10/10, included that assessment of a resident ' s skin integrity should guide the development and</p>	F 314			

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F 314	Continued From page 27 implementation of repositioning plans. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing. The facility failed to consistently provide a pressure relieving device in the recliner and the wheelchair, as planned, placing the resident at risk for further pressure ulcer development.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility reported a census of 40 residents with 5 resident 's sampled for review of urinary incontinence. Based on observation, interview, and record review, the facility failed to complete a complete urinary assessment and provide individualized toileting for 2 of the 5 residents reviewed (resident # 5 and 2), to ensure the residents maintained as much normal bladder function as possible. Findings included:	F 315		

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F 315	<p>Continued From page 28</p> <p>- Resident #5 ' s signed physician orders, dated 8/16/16 included a diagnosis of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain).</p> <p>An admission MDS assessment, dated 7/20/16 identified the resident scored 3/15 on the Brief Interview for Mental Status assessment, indicating severely impaired cognition and needed extensive assist of 1 staff for transfers and locomotion, and needed limited assistance of 1 staff for walking and toileting. The assessment identified the resident lacked a toileting program and was always continent of bladder.</p> <p>The 7/22/16 Care Area Assessment for urinary incontinence included: The resident calls for assistance for toileting and is continent of bladder at that time</p> <p>The quarterly Minimum Data Set assessment, dated 9/23/16, identified the resident scored 3/15 on the Brief Interview for Mental Status assessment, indicating severely impaired cognition and indicated the resident as frequently incontinent of urine and on a toileting program.</p> <p>A voiding evaluation, dated 10/4/16 identified the resident incontinent of urine and needed habit training and scheduled voiding. Documentation indicated the staff prompt and assist the resident to the toilet every 2 hours and PRN (as needed). The evaluation lacked a voiding diary, to determine the resident's individual toileting needs.</p> <p>The resident ' s care plan, dated 7/28/16 included:</p> <p>The resident is continent of bladder, at that time,</p>	F 315		

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F 315	<p>Continued From page 29</p> <p>however, resident does experience urgency and needs his/her call light answered immediately.</p> <p>On 10/12/16 staff changed the care plan to reflect the resident required 1 staff participation to use the toilet. Staff to prompt and assist to the toilet every 1-2 hours during AM/PM and every 2-3 hours at bedtime. The plan of care failed to address the resident's individualized toileting needs.</p> <p>On 10/18/16 at 10:45 AM the resident sat in the recliner in his/her room, covered with a blanket and appeared to sleep. Intermittent observations from 10:45 AM until 1:00 PM, at 11:00, 11:15, 11:30, 11:45, 12:00, 12:15, 12:30, and 12:45 PM identified no significant changes in the resident ' s position or care provided by any staff member, per interview with the resident ' s visiting family. At 1:00 PM, direct care staff K assisted the resident to the toilet then licensed nursing staff D stepped in to assist with completion of cares. Staff K reported the brief they removed from the resident was wet with urine and reported that sometimes the resident was wet and sometimes was continent of urine. Staff provided perineal care to the resident and then placed a clean brief on the resident.</p> <p>10/20/16 at 3:10 PM, direct care staff I and licensed nurse E, assisted the resident with toileting, ambulating to the bathroom. The resident was noted to have a wet brief, with staff providing perineal care to the buttocks and front perineal areas before placing a dry brief on the resident.</p> <p>Interview, on 10/18/16 with the resident ' s family reported the prior day they visited the resident and found the resident in bed, with a staff</p>	F 315			

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F 315	<p>Continued From page 30</p> <p>member feeding him/her in bed. The resident ' s brief, when the staff assisted the resident out of bed was saturated to the point that the brief fell down when staff ambulated the resident to the bathroom.</p> <p>Direct care staff K reported, on 10/18/16 at 2:30 PM, the resident was often continent of bladder and that he/she needed toileting every 2 hours or sooner when requested.</p> <p>On 10/19/16 at 4:46 PM, direct care staff M, reported the resident was total care and incontinent of bladder with a toileting plan of every 2 hours. Staff reported they had never completed a 3 day voiding pattern on any resident in the facility.</p> <p>On 10/19/16 at 9:30 AM, licensed nursing staff F, reported the resident was incontinent of urine and needed toileting assistance of staff.</p> <p>Administrative nursing staff B reported on 10/20/16 the facility completed the voiding evaluation, however, was not able to locate a 3 day voiding diary, for the resident.</p> <p>The facility policy dated 8/15, for Urinary Incontinence, included using a standardized assessment tool to determine the cause of the incontinence and determining the resident ' s type of voiding program needed.</p> <p>The facility failed to develop and provide an individualized toileting plan to ensure the resident maintained as much normal bladder function as possible.</p> <p>- RESIDENT # 2 ' s admission Minimum Data</p>	F 315			

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F 315	<p>Continued From page 31</p> <p>Set assessment, dated 5/20/16, included the resident unable to complete the Brief Interview for Mental Status assessment and staff assessed the resident with intact memory, and needed total dependence for bed mobility, transfers, toileting and personal hygiene with functional limitation in ROM to bilateral sides to upper and lower extremities. The assessment identified the resident always incontinent of bladder.</p> <p>The quarterly Minimum Data Set assessment, dated 7/27/16, indicated the resident scored 6/15 on the Brief Interview for Mental Status assessment, without changes to his/her ADL ' s or incontinence status.</p> <p>The 5/20/16 Care Area Assessment for cognition included: Resident appears to have some cognitive deficits. The extent is unknown d/t the resident ' s inability to respond consistently.</p> <p>The 5/20/16 Care Area Assessment for UI included Resident will remain free from skin breakdown due to incontinence and brief use. Nursing will check and change every 2-3 hours and as required for incontinence and wash, rinse and dry perineum with every incontinent episode. Change clothing PRN after incontinence episodes.</p> <p>A 10/15/16 urinary evaluation included the resident was incontinent of urine following a 3 day voiding diary, identified the resident would require a habit/scheduled voiding program, related to mixed incontinence. The evaluation lacked a voiding diary, to determine the resident's individual toileting needs.</p> <p>A care plan, dated 10/10/16, included:</p>	F 315			

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F 315	<p>Continued From page 32</p> <p>7/15/16 BRIEF USE: use disposable briefs for dignity. Wash, rinse and dry perineum with every incontinent episode. Change clothing PRN (as needed) after incontinence episodes.</p> <p>9/20/16 TOILETING ROUTINE: Toilet every 1 hour until the residents brief is not wet for 12 toilettings then increase to every 2 hours and notify staff to update the care plan. The resident is to be toileted 1 time each shift on the commode. The plan of care failed to address the resident's individualized toileting needs.</p> <p>On 10/18/16 at 8:38 AM, direct care staff K and L checked the resident for wetness after laying the resident in the bed, and found the resident to be dry. No offer of toileting was made. Staff K reported the resident is incontinent of urine at all times. At 11:33 AM direct care staff K and L checked and changed the resident and removed a urine wet brief, provided perineal care appropriately and then transferred the resident into a broda chair for lunch. Again, no offer of toileting was made or attempted. At 3:00 PM, the resident was restless and calling out to staff to get him/her up. Staff P responded to the resident that it was too early to get out of bed before supper. During this interaction, the staff failed to offer toileting, check and change or any type of cares to alleviate the resident ' s restlessness. At 4:30 PM, direct care staff P and Q changed the resident ' s wet incontinent brief and provided perineal care before transferring the resident into the broda chair.</p> <p>Direct care staff K reported on 10/18/16 at 2:53 PM, the resident was incontinent of bladder and staff checked and changed the resident routinely, and were suppose to toilet the resident 1 time per shift. The staff reported the resident is planned</p>	F 315			

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F 315	<p>Continued From page 33</p> <p>for check and change every hour, but confirmed that did not always happen. Staff reported the resident is not resistant to cares at all.</p> <p>On 10/19/16 at 4:55 PM, direct care staff M reported the resident required total care for ADL 's (activities of daily living), was incontinent of bladder and rarely ever toileted. The staff reported the resident seemed to be getting some sensation of voiding back, as the resident will frequently state he/she is wet, but when checked he/she is not. The resident needed much encouragement for toileting on the commode.</p> <p>On 10/20/16 at 2:25 PM, licensed nursing staff E reported the resident was a check and change, with attempts daily to toilet. The nurse reported they were unaware the resident refused to sit on the toilet or commode.</p> <p>On 10/20/16 at 3:35 PM administrative nursing staff B reported being unaware of the resident 's refusal to toilet.</p> <p>The facility policy dated 8/15, for Urinary Incontinence, included using a standardized assessment tool to determine the cause of the incontinence and determining the resident 's type of voiding program needed.</p> <p>The facility failed to develop an individualized toileting plan to consistently toilet this resident to restore as much normal bladder function as possible.</p>	F 315		